

**Attachment B  
Bidder Questionnaire  
RFP XXXX Z1**

**Bidder Name:** \_\_\_\_\_

**Bidder should complete all questions provided in this attachment.**

<b>Req #</b>	<b>TECHNICAL APPROACH</b>
<b>PLAN REQUIREMENTS</b>	
<b>1.1</b>	Proposals must include a current comparison to other state and large employers based on the claims data provided and current prescription programs in place at the State. This comparison should include but not be limited to the Bidder's suggestions for modifications to existing programs, the addition of new programs and or recommendations for changes in the State's policies on how to improve the State's performance and specific methods to reduce costs.
<b>Response:</b>	
<b>HIPAA</b>	
<b>1.2</b>	The Bidder should provide and describe their capabilities in offering the State an annual HIPAA training seminar to comply with the annual education and training requirements as defined by HIPAA at no cost to the State
<b>Response:</b>	
<b>GENERAL PLAN INFORMATION AND REQUIREMENTS</b>	
<b>1.3</b>	Organization name
<b>Response:</b>	
<b>1.4</b>	Primary and Secondary Contact to include: <ul style="list-style-type: none"> <li><b>a.</b> Name</li> <li><b>b.</b> Title</li> <li><b>c.</b> Address</li> <li><b>d.</b> City</li> <li><b>e.</b> State</li> <li><b>f.</b> Zip</li> <li><b>g.</b> Telephone #</li> <li><b>h.</b> Fax #</li> <li><b>i.</b> E-mail Address</li> </ul>
<b>Response:</b>	

1.5	Bidder shall provide a copy of a Suggested Employer Contract with a statement that the sample include all exclusions and limitations that will apply to a policy issued to the State.
Response:	
1.6	Describe any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.
Response:	
1.7	Bidder will not render or administer services offshore, and all work performed will be in the contiguous United States.
Response:	
<b>MEMBER SERVICES</b>	
1.8	Describe whether members reach a live representative or an interactive voice response unit (IVR) when calling Member Services.
Response:	
1.9	Describe the system by which the Customer Service unit tracks and documents calls. Describe the process to review the findings of the call tracking and documentation process with the State.
Response:	
1.10	Do members have access to the claims/Member Service group via e-mail or internet? If yes, please specify feature available (e-mail, web chat, etc.).
Response:	
1.11	Describe the escalation process for Member Services satisfaction and complaints.
Response:	
1.12	Bidder should provide detailed information on how often provider directories are updated. Both hard copy and on-line provider directories must be made available by the Contractor to the State of Nebraska
Response:	

1.13	Where will the Customer Service unit be located?
Response:	
1.14	What is your current process for handling calls "after hours" of operation? Is there a voicemail system or capability for caller to leave messages after normal business hours?
Response:	
1.15	Confirm your ability to meet a 24-Hour Nurse Line program, staff must be available 24-hours a day, 365 days a year.
Response:	
1.16	Do you provide a drug cost look-up tool on your member website that provides both the plan copay and full drug cost?
Response:	
1.17	Describe whether members reach a live representative or an interactive voice response unit (IVR) when calling Member Services.
Response:	
1.18	Describe the escalation process for Member Services satisfaction and complaints
Response:	
1.19	Bidder should provide detailed information on how often provider directories are updated. Both hard copy and on-line provider directories must be made available by the Contractor to the State of Nebraska. Contractor must provide hard-copy provider directories to current and prospective members within three business days of request.
Response:	
1.20	Do members have access to the claims/Member Service group via e-mail or internet? If yes, please specify features available (e-mail, web chat, etc.).
Response:	

MEDICAL PLAN DESIGN	
1.21	Bidder proposal will be issued in accordance with the specifications and information, including the full Summary Plan Descriptions (SPD) of each plan offered by the State, referenced in this RFP.
Response:	
1.22	Bidder will include a concise description of how this health plan covers transitional conditions, such as pregnancy, chemotherapy, etc., if a new member is receiving treatment from a non-participating provider.
Response:	
DATA ANALYTICS TOOL	
1.23	<p>Please provide proof your data analytics tool has the ability to provide and calculate:</p> <ol style="list-style-type: none"> <li>1. Provide proof of these Variables;               <ol style="list-style-type: none"> <li>a. Health Plan type/ Option</li> <li>b. Member Status( Active, Early Retiree, Retiree)</li> <li>c. Relationship (Employee, Spouse, Dependent)</li> <li>d. Network Indicator</li> <li>e. Place of Service (Inpatient, Outpatient, Emergency Room, Physician's office, etc.)</li> <li>f. Major Diagnostic Category</li> <li>g. Diagnosis Related Group</li> <li>h. Member ID</li> <li>i. Provider ID</li> <li>j. Date of Service</li> <li>k. Date of Payment</li> </ol> </li> <li>2. Provide proof these Calculations;               <ol style="list-style-type: none"> <li>a. Admissions</li> <li>b. Readmissions (7,15,30 days)</li> <li>c. Urgent Care Visits</li> <li>d. Other Facilities</li> <li>e. Avoidable Admissions</li> <li>f. Inpatient Days</li> <li>g. Emergency Room Visits</li> <li>h. Office Visits</li> <li>i. Preventive Screens</li> <li>j. Total number of claims</li> <li>k. Net Payment</li> <li>l. Healthcare Reimbursement Amount</li> <li>m. Copayment Amount</li> <li>n. Coinsurance Amount</li> <li>o. Deductible Amount</li> </ol> </li> </ol>
Response:	

1.24	How you will provide State staff access to your data warehouse?																																																																	
Response:																																																																		
1.25	What training will you provide the State on these tools?																																																																	
Response:																																																																		
<b>CLAIMS PROCESSING</b>																																																																		
1.26	Please state if any additional hours open beyond the core hours described above.																																																																	
Response:																																																																		
1.27	Bidder must describe their performance standards with respect to: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 80%;"> <p>a. Adherence to implementation/annual enrollment timeline</p> <p>b. Readiness of claims and customer service systems</p> <p>c. Readiness of eligibility system</p> <p>e. Completion of plan documents</p> </div> <div style="width: 15%;"> <p>d.</p> <p>f.</p> </div> </div>																																																																	
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1.28	Bidder must provide their actual (achieved) performance measurements for an account size comparable to the State of Nebraska for 2016 and 2017 as well as their 2016 and 2017 performance standards targets for the claims office that will handle the State account. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Performance Measure</th> <th>2016 Performance Targets</th> <th>2016 Performance Actuals</th> <th>2017 Performance Targets</th> <th>2017 Performance Actuals</th> <th>PG Measurement Utilized</th> </tr> </thead> <tbody> <tr> <td>Member Satisfaction Survey (% satisfied)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Claim Administration</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Claim Accuracy (percentage)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Financial Accuracy (percentage)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Claims Turnaround Time (days)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Overpayment recoveries (number of days to send check for overpayment)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Customer Service</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Telephone call response time (seconds)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>First call resolution rate (percentage)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Performance Measure	2016 Performance Targets	2016 Performance Actuals	2017 Performance Targets	2017 Performance Actuals	PG Measurement Utilized	Member Satisfaction Survey (% satisfied)						Claim Administration						Claim Accuracy (percentage)						Financial Accuracy (percentage)						Claims Turnaround Time (days)						Overpayment recoveries (number of days to send check for overpayment)						Customer Service						Telephone call response time (seconds)						First call resolution rate (percentage)					
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	Closure time for open inquiries (number of days)					
	Timeliness of responding to web inquiries (number of days)					
	Timeliness of resolution for grievances, complaints and appeals					
<b>Response:</b>						
1.29	What percentage of claims were received electronically in 2017 for: <ul style="list-style-type: none"> <li>a. Hospital/Facility services</li> <li>b. Physician services</li> <li>c. Laboratory, Radiology, etc.</li> <li>d. Overall total</li> </ul>					
<b>Response:</b>						
1.30	Bidder should provide auto-adjudication rate for clean claims received electronically in 2017 for: <ul style="list-style-type: none"> <li>a. Hospital/Facility services</li> <li>b. Physician services</li> <li>c. Laboratory, Radiology, etc.</li> <li>d. Overall total</li> </ul>					
<b>Response:</b>						
1.31	Bidder should describe their internal audit procedures including if audits are performed on a pre- or post-disbursement basis, what percentage of all claims are audited by an internal audit group, how claims are selected for internal audit and what triggers are utilized.					
<b>Response:</b>						
1.32	Bidder should provide in detail their procedure for processing claims based on benefit exceptions of denied claims as determined by the State.					
<b>Response:</b>						
1.33	The State requires claims history be maintained on-line for a minimum of ten (10) years. Bidder should provide detail on how they meet and/or exceed these requirements.					
<b>Response:</b>						

1.34	Bidder should provide detail on how they determine usual, customary and reasonable charges for out-of-network medical, surgical and anesthesia.
<b>Response:</b>	
1.35	Bidder should describe how claims are reviewed for billing irregularities by a provider (such as regular overcharging, unbundling of procedures, up coding or billing for inappropriate care for stated diagnosis, etc.).
<b>Response:</b>	
1.36	Bidder should provide a sample of proposed claim and Explanation of Benefits (EOB) forms with proposal.
<b>Response:</b>	
1.37	What procedures do you use to administer the COB provision?
<b>Response:</b>	
1.38	Bidders should provide a list of the location(s) of your service centers that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location.
<b>Response:</b>	
1.39	Bidders should provide a description of premium or administrative fee billing procedures, including information on the timing of billing, billing-payment reconciliations and ability to provide for State self-billing.
<b>Response:</b>	
1.40	Bidders should indicate for any current plan, under what circumstances members are required to submit claim forms and bills: <ul style="list-style-type: none"> <li>a. In-Network</li> <li>b. Out-of-Network</li> <li>c. Out-of-Area</li> <li>d. Out-of-Country</li> </ul>
<b>Response:</b>	

## BEHAVIORAL HEALTH

**1.41** Provide a brief overview of your program and address how your behavioral health management interventions are integrated with your medical management interventions.

**Response:**

**1.42** Is any aspect of the behavioral health program subcontracted?

- a. If yes, identify the program, the subcontractor, and background on your organization's relationship with them.
- b. Describe how plan participants access the behavioral health service.

**Response:**

**1.43** Are specialty case managers used to manage Mental Health/Substance Abuse (MH/SA) cases? What are their credentials?

**Response:**

**1.44** Does the same case manager handle the member's care through all levels of care? For example, inpatient, intermediate, and outpatient?

**Response:**

**1.45** How long is a patient monitored after discharge?

**Response:**

**1.46** How frequently are outpatient cases evaluated for case management?

**Response:**

**1.47** Are out-of-network cases considered for case management?

**Response:**

**1.48** What methods does your organization have available to ensure appropriateness of treatment (utilization and duration)?

**Response:**

1.49	Do MH/SA case managers routinely co-manage cases with medical and/or disease management case managers?
Response:	
1.50	The bidder should detail options available to the card programs to make payments to entities that do not accept the branded card used by the Contractor. The bidder should include information on payable automation services available to card programs.
Response:	
1.51	The bidder should detail programs available that can increase rebates to card programs.
Response:	
1.52	Will you be able to report State-specific outcomes data? If yes, please describe the type of reporting available.
Response:	
<b>ELIGIBILITY AND MEMBERSHIP</b>	
1.53	Is eligibility processed in real time with the claims system?
Response:	
<b>WEB ACCESS</b>	
1.54	<p>Please describe in detail: Member capabilities to include the following, but not limited to;</p> <ul style="list-style-type: none"> <li>a. Print ID cards directly from site</li> <li>b. Access historical health data</li> <li>c. Provider directories</li> <li>d. Provider selection where users enter search criteria</li> <li>e. Claim status review</li> <li>f. Plan design</li> <li>g. Ability to email member services</li> <li>h. Customizable health content tools</li> <li>i. Tools available to evaluate cost and/or quality of healthcare providers</li> <li>j. On-line access to claim processing status and appeals by the member</li> <li>k. Applications for mobile devices</li> <li>l. Request additional or replacement ID cards</li> <li>m. Ability to customize web site for the State</li> <li>n. Ability to hot link to the State's site</li> <li>o. Future plans/timeframes for enhancements</li> <li>p. Employer/actuarial consultant inquiry capabilities</li> </ul>

q. Security/privacy issues

Response:

#### MEDICAL PROVIDER NETWORK

1.55

Bidder should indicate whether the Geo-Access reporting has been completed using the requested parameters below. Please note geo-mapping method used.

Practice Specialty	Number of Providers Available	Miles from Employees Residence
Adult Physicians (Family Practice, General Practice, General Internal Medicine)	2	8
General Pediatricians	2	8
Obstetricians/Gynecologists	2	8
Acute Care Hospitals	1	15

Response:

#### Network / Provider Arrangements

1.56

- Bidder should indicate whether the network proposed for the State is leased or owned or a combination.
- If a combination, bidder should indicate what percent is leased and what percent is owned.
- If any portion of the network is leased, bidder should provide the name of network lessee.
- As the result of this arrangement, the State will require no impact on preauthorization, quality assurance and hold harmless arrangements. Bidder should indicate how this requirement will be met.
- Bidder should indicate how negotiated discounts for leased networks are on-line and fully integrated with their claims system.
- Bidder should indicate which accreditation was selected, provide the date of accreditation, and give analysis on why said accreditation was selected.
- Bidder should describe in detail any restrictions or exclusive requirements for any provider Network included in their bid.
- Bidder should indicate if they maintain separate provider contracts for PPO and POS networks and describe in detail the reasoning and methodology behind such provider contracts.
- Bidder should indicate how Centers of Excellence are utilized for high intensity procedures:
  - List of Centers of Excellence by procedure
  - Method of referral to Centers of Excellence
  - Credentialing process for Center Excellence

- j. Bidder should indicate ongoing provider quality monitoring activities, such as physician profiling
- k. Bidder should provide the average medical provider discounts (based on allowed amounts) the bidder has under contract for the list of three digit zip codes below:

**Response:**

Please provide discount off allowed amounts for Physician and Hospital In-Patient and Outpatient for the following locations.

1.57

3 Digit Zip Code	Discount off ALLOWED Charges		
	Inpatient Hospital	Outpatient Hospital	Physician
693			
692			
691			
690			
689			
688			
687			
686			
685			
684			
683			
681			
680			
3 Digit Zip Code	Discount off ALLOWED Charges		
	Inpatient Hospital	Outpatient Hospital	Physician
515			
511			

**Note: Provide separate table for each proposed network, PPO or POS.**

**Response:**

<b>1.58</b>	Bidder should provide the trend rates for the last five years for your PPO plans and your POS plans.
<b>Response:</b>	
<b>1.59</b>	Bidder should provide information on average in-network participation by provider and by claims paid for 2016 and 2017 for their clients located in Nebraska.
<b>Response:</b>	
<b>1.60</b>	Bidder should indicate its capability to develop and administer a network specifically for the State based upon State-defined criteria.
<b>Response:</b>	
<b>1.61</b>	<p>1. Network / Physician</p> <ul style="list-style-type: none"> <li>a. Bidder should provide the ratio of physicians to members maintained in the State of Nebraska's provider network.</li> <li>b. Bidder should provide the ratio of participating specialists to physicians in the State of Nebraska's provider network.</li> <li>c. Bidder should indicate if there are any medical services or specialties that are not available in bidder's physician networks in the service areas where there are plan members. Bidder should indicate what services are not available. Bidder should indicate what provisions are made for patients requiring these services.</li> <li>d. Bidder should indicate how the State would be informed of the termination of a provider.</li> <li>e. Bidder should indicate the contract period for physicians.</li> <li>f. Bidder should indicate how often their physicians are credentialed.</li> <li>g. Bidder should describe their physician credentialing process, specifically if your selection and credentialing process allows you to decline an individual physician or provider group or organization? What is the average time to credential and add an individual physician? What is the average time to credential and add a medical group?</li> <li>h. Bidder should indicate if physicians in their networks bid may limit the number of patients/cases that they accept. If so, bidder should indicate how the limit is determined and what the limit is.</li> <li>i. Bidder should indicate what percentages of physicians in your provider network bid for the State's health plan are at full capacity.</li> <li>j. Bidder should indicate if a network gap or deficiency is identified by the Bidder or the State. How do you address the need for additional providers?</li> </ul>
<b>Response:</b>	

1.62	<p>2. Network / Hospital</p> <ol style="list-style-type: none"> <li>Bidder should indicate what criteria are used to select hospitals and other health care facilities to participate in the bidder's network.</li> <li>Bidder should indicate which of the hospitals participating in any network bid are accredited by JCAHO and which are not.</li> <li>Bidder should indicate what liability coverage limits the participating hospitals are required to carry.</li> <li>Bidder should indicate if any hospitals or other medical facilities have been terminated or dropped from the network bid; if so, bidders should identify hospital/medical facility and for what reason(s).</li> <li>Bidder should indicate what percentage of hospitals/facilities in Nebraska are in bidder's provider network.</li> <li>Bidder should indicate what provisions are made for enrolled patients when hospitals/facilities leave the bidder's provider network.</li> <li>In the event that any of the Contractor's medical facilities are unable to provide service due to complete or partial destruction, labor disputes, epidemic or other causes, the Contractor shall make a good faith effort to arrange to have the services (to which a member is entitled) provided by other facilities and providers of services. Bidder should explain how they intend to comply with this provision.</li> <li>In addition to the hospitals in the bidder's provider network, bidder should list all other types of facilities and ancillary providers available through the bidder's hospital provider network and indicate how each is paid.</li> <li>Bidder should indicate if there are any forms of treatment that cannot be provided by bidder's hospital provider network; if so, bidder should indicate which ones. Bidder should indicate what arrangements are made for the provision of these necessary services.</li> <li>Bidder should indicate if negotiated hospital rates are guaranteed for a period of time; if rates are guaranteed, indicate the length of such guarantee.</li> <li>Bidder should indicate how they intend to comply with this provision.</li> <li>Bidder should indicate if they have designated facilities for specific specialty care for services such as transplants, etc. and describe such arrangements in detail.</li> </ol>
Response:	
QUALITY ASSURANCE	
1.63	<p>Bidder must provide a quality assurance program in terms of any qualitative and quantitative measures used in the program.</p> <ol style="list-style-type: none"> <li>Describe how these programs are communicated to providers within bidder's network(s).</li> <li>Describe how these programs are communicated to health plan members</li> </ol>
Response:	

## UTILIZATION MANAGEMENT /CASE MANAGEMENT

**1.64**

Bidder should describe their preauthorization and utilization review services in detail, including information on the following:

- a. Location of the office providing preauthorization and utilization review services Relationship with any subcontractors and current procedures with them to integrate data, criteria and program results

**Response:**

**1.65**

Bidder should identify the guidelines that are used to support UM/CM decisions.

- a. Who is responsible for follow up after discharge?
- b. Does this protocol apply to all discharges or is it limited to those with identified medical needs at discharge?
- c. How is follow up after discharge tracked?
- d. Processes in place to assist individuals in obtaining qualified medical services at a low cost
- e. Does a single/same case manager follow the case throughout its course in case Management?
- f. Does the case manager serve as the primary reviewer if the patient is readmitted to an acute care setting?

**Response:**

**1.66**

Bidder should describe their UM/CM program in detail, including information on the following:

- a. Management of complex cases
- b. Identification of complex cases
- c. Capability to automatically match claims with utilization management information both in- and out-of-network
- d. Management of special needs cases (traumatic brain injury, co-morbid conditions, neonatal cases, etc.)
- e. Ratio of case managers per 1,000 members
- f. Methodology of determining ROI for reporting on direct and indirect savings related to your case management program

**Response:**

**1.67**

Bidder should describe how their predictive modeling capabilities identify at-risk members and potential interventions the State should consider.

**Response:**

1.68	Bidders should include Utilization Management/Case Management programs as outlined here in their Administrative Services Only (ASO) Fee.
Response:	
1.69	Describe interventions that take place and level of staff providing interventions. Address how your services are integrated with utilization management and behavioral management, and how you assist members in maximizing their benefits while containing Plan costs.
Response:	
1.70	Describe the degree to which your medical management programs are integrated within your organization (i.e., electronic systems integration, etc.).
Response:	
<b>DISEASE MANAGEMENT</b>	
1.71	Bidder should provide an engagement model DM program (opt-out) that includes, at a minimum, asthma, diabetes for adult, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and co-morbid conditions. Your DM program must include a proven methodology for calculating and reporting a return on investment (ROI). List and discuss all DM programs currently available.
Response:	
1.72	What percentage of participants identified as candidates for DM and enrolled in the programs are actively participating, with a minimum of quarterly engagements, i.e., phone calls, face-to-face, and virtually?
Response:	
1.73	What percentage of participants identified and enrolled for DM receive only written communication, e.g. general health newsletters, disease specific educational materials ?
Response:	

1.74	Identify the total number of participants of a similar account size to the State of Nebraska that are managed within the DM programs by diagnosis for calendar year 2017.
Response:	
1.75	Describe how you will monitor and report compliance and participation on a quantified basis.
Response:	
1.76	Describe how long each program has been in effect, whether the program is subcontracted to another firm, and the performance results and anticipated ROI for each program, the total number of employees eligible for each program within your book of business in 2017.
Response:	
1.77	<p>Describe:</p> <ul style="list-style-type: none"> <li>a. Eligibility</li> <li>b. Centralized electronic medical records.</li> <li>c. Medical Community integration processes and program details</li> <li>d. Education materials</li> <li>e. Identification, participation, engagement</li> <li>f. Risk stratification methodology</li> <li>g. Predictive modeling capabilities.</li> <li>h. Process to include individuals in the disease management program once their paid claims exceed \$50,000</li> </ul>
Response:	
1.78	Describe the interaction you have with participant's attending physician. Indicate any standards related to frequency and content of contacts.
Response:	
1.79	What are the qualifications for the staff that manage the DM cases?
Response:	

1.80	For the diagnoses that are managed in DM, indicate if your organization has seen a resulting decrease in the admissions / ER visits for these diagnoses from the year prior to the program being implemented. If so, provide the percentage decrease.
<b>Response:</b>	
1.81	If your organization has not seen a decrease in the hospitalizations for the diagnoses managed through DM, please provide your assessment as to why this may not have occurred including what corrective actions were taken.
<b>Response:</b>	
1.82	If a participant has more than one DM diagnosis, describe how your programs manage their care.
<b>Response:</b>	
1.83	Discuss your ability to administer copay waivers or customized member cost sharing based on individual member eligibility within the same plan options. For example, diabetics participating in a diabetic DM program may receive copay waivers for routine office visits.
<b>Response:</b>	
1.84	Provide a case study that highlights your success in providing customized programs and solutions to a customer with similar characteristics as the State. Describe the goals, initiatives developed to achieve the goals, and successes and challenges in implementing the initiatives. Include specific metrics and outcomes measured to determine success.
<b>Response:</b>	
1.85	Confirm that prior Wellness and DM program history from the State's existing services can be utilized to transition Wellness and DM services.
<b>Response:</b>	

## MEDICAL REPORTING

Bidder should attach sample management and utilization report(s) that would be prepared for the State. Items 1 through 10 are minimum reporting requirements for the State:

### 1. Daily Reporting

The State requires a daily reporting of claims paid in a format acceptable to meet State requirements for Contractor reimbursement; such format shall be determined during contract finalization with the specified Contractor. The following are required data fields for daily reporting and should not include Personal Health Information (PHI):

- a. Policy/Group/Plan Number
- b. Claim Number
- c. Payee
- d. Provider Name
- e. Claim Expense Incurred Date
- f. Claim Payment Date
- g. Claim Process Date
- h. Claim Billed Amount
- i. Claim Allowed Amount
- j. Claim Paid Amount

### 2. Monthly reporting containing the following information:

- a. Paid claims
- b. Administrative/Network Fees (if applicable)
- c. Individual claims > 50% pooling/stop loss levels
- d. Monthly enrollment counts
- e. Reconciliation of claim drafts to paid claims
- f. ASO reconciliation of monthly PEPM Administrative Fees

### 3. Annual Reports

- a. General claim utilization reports by major line of coverage identifying:
  - i. Claims submitted
  - ii. Claims eligible
  - iii. Deductible and coinsurance application
  - iv. Payment reductions due to network negotiated rates
  - v. Reasonable and Customary cutbacks and savings
  - vi. COB savings
  - vii. Ineligible expenses
  - viii. Net benefits paid by major line of coverage

### 4. Consultative Reports

- a. Reports that analyze utilization of healthcare services of plan members:
  - i. Identifies opportunities for plan design or care management interventions

1.86

	<ol style="list-style-type: none"> <li>5. Claim utilization report will show separate experience for:               <ol style="list-style-type: none"> <li>a. Members</li> <li>b. Dependents</li> <li>c. COBRA Participants</li> <li>d. Retirees</li> </ol> </li> <li>6. Employee contested claims separated by denial reason</li> <li>7. Claim lag report.</li> <li>8. Network savings reports for each network offered</li> <li>9. Most utilized hospitals and physicians reports</li> <li>10. A year-end financial accounting for the program within 90 calendar days after fiscal year end</li> </ol>
<b>Response:</b>	
<b>1.87</b>	Describe Ad Hoc Reporting Capability – both online and paper formats.
<b>Response:</b>	
<b>1.88</b>	Describe how your reporting capabilities (other than the ones required in points 1-10 immediately above) would provide value to the State.
<b>Response:</b>	

## PHARMACY BENEFITS REPORTING

1.89	<p>Please provide a copy and your frequency of each report</p> <ul style="list-style-type: none"> <li>a. Eligibility Report which shows accuracy of updates and changes</li> <li>b. Paid Claims Summary (Ingredient cost, days' supply, dispensing fees, taxes, copay totals by month)</li> <li>c. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the Drug name and dosage, submitted charge, allowable charge, paid)</li> <li>d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)</li> <li>e. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average days' supply)</li> <li>f. Top Drug Report (detail of cost and utilization by top drug products)</li> <li>g. High Amount Claimant report</li> <li>h. Therapeutic Interchange Report detailing success rates and cost impacts of Contractor initiated interchanges</li> <li>i. Drug Utilization Review activity and Savings Report by type of edit</li> <li>j. Member compliance and adherence to therapy</li> <li>k. Formulary Savings and Rebate report</li> <li>l. Paid Claims Summary (see b.) showing total number of claims, eligible charges and claim payments for each category</li> <li>m. Prior Authorization and other clinical program reporting</li> <li>n. Specialty Rx reporting</li> <li>o. Pharmacy cost and utilization reporting</li> </ul>
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**Response:**

## REBATE AND FORMULARY MANAGEMENT

1.90	<p>Bidder should provide a disruptive analysis comparing the State's current formulary. To assess the impact of changing the formulary.</p> <p><a href="http://das.nebraska.gov/Benefits/Active/2018/2018PrescriptionDrugList.pdf">http://das.nebraska.gov/Benefits/Active/2018/2018PrescriptionDrugList.pdf</a></p>
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**Response:**

1.91	<p>Are any generic drugs considered "non-preferred" on your proposed formulary (i.e., subject to the "non-preferred" copay)? If yes, please describe in detail and provide examples.</p>
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**Response:**

<b>1.92</b>	<p>Does your formulary currently exclude any prescription drugs from coverage?</p> <p>If yes:</p> <ul style="list-style-type: none"> <li>a. provide a list of those excluded from coverage</li> <li>b. indicate the notification process for any future changes to the exclusion list, including the amount of advanced notification you will provide to the State and its employees and the form the notification will take</li> </ul> <p>If no:</p> <ul style="list-style-type: none"> <li>c. Will you confirm that no such future exclusions will be required during the term of this contract?</li> </ul>										
<b>Response:</b>											
<b>1.93</b>	<p>Do your manufacturer agreements contain provisions that limit the amount the manufacturer can raise the AWP price of prescription drugs each year? If yes, please describe.</p>										
<b>Response:</b>											
<b>1.94</b>	<p>What reporting will you provide to the State to demonstrate such manufacturer price limit agreements provide meaningful benefits to the State?</p>										
<b>Response:</b>											
<b>PHARMACY NETWORK ACCESS AND MANAGEMENT</b>											
<b>1.95</b>	<p>What is the current number of retail pharmacies in your network?</p>										
<b>Response:</b>											
<b>1.96</b>	<p>List any pharmacy chains excluded from your proposed retail pharmacy network.</p>										
<b>Response:</b>											
<b>1.97</b>	<p>Perform and provide a GeoAccess analysis based on your contracted pharmacy network using the Census provided in below.</p> <p>The access standards in the table below will be utilized in the analysis.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <th style="width: 25%;">Provider Type</th> <th style="width: 25%;">Urban Enrollees</th> <th style="width: 25%;">Suburban Enrollees</th> <th style="width: 25%;">Rural Enrollees</th> </tr> <tr> <td style="text-align: center;">Pharmacies</td> <td style="text-align: center;">2 in 5 miles</td> <td style="text-align: center;">2 in 10 miles</td> <td style="text-align: center;">2 in 20 miles</td> </tr> </table>			Provider Type	Urban Enrollees	Suburban Enrollees	Rural Enrollees	Pharmacies	2 in 5 miles	2 in 10 miles	2 in 20 miles
Provider Type	Urban Enrollees	Suburban Enrollees	Rural Enrollees								
Pharmacies	2 in 5 miles	2 in 10 miles	2 in 20 miles								
<b>Response:</b>											

1.98	Provide the number of participating retail pharmacies that were terminated from the network in the past 24 months:			
	<b>Termination Rates</b>	<b># of Pharmacies</b>	<b>% of Pharmacies</b>	<b>Reasons for Terminations</b>
	<b>By Your Organization+</b>			
	<b>By Pharmacy++</b>			
+when the termination is initiated by the Contractor ++when the termination is initiated by a pharmacy				
<b>Response:</b>				
1.99	An Excel file named Rx Providers – will be provided in Census Data File Attachment A- it contains a pharmacy utilization file representative of the Rx Utilization experience for the State's membership. For each pharmacy listed, please indicate if the pharmacy is in the network (i.e., a participating provider) for the plan you are proposing.			
<b>Response:</b>				
1.100	The State has designed its pharmacy plan benefits to minimize the use of manufacturers' coupons or savings cards. Do your retail network agreements allow pharmacies to utilize manufacturer coupon and other programs to circumvent plan design incentives and disincentives? What actions does your organization take to deter or minimize the use of manufacturer's coupons?			
<b>Response:</b>				
<b>MAIL ORDER</b>				
1.101	Describe the locations of all of your Mail Order facilities nationwide			
<b>Response:</b>				

<b>1.102</b>	What is your standard floor limit for accepting prescription orders from members without the correct payment?
<b>Response:</b>	
<b>SPECIALTY PHARMACY</b>	
<b>1.103</b>	Please provide location information on Specialty Pharmacy if different from Mail Order Facility.
<b>Response:</b>	
<b>1.104</b>	Is your specialty pharmacy part of a specialty pharmacy network?
<b>Response:</b>	
<b>1.105</b>	Does your organization own a specialty pharmacy?
<b>Response:</b>	
<b>1.106</b>	Please provide your organization's definition and qualification criteria of a specialty drug.
<b>Response:</b>	
<b>1.107</b>	Describe how your organization notifies clients of the pricing terms for new specialty drugs including how far in advance such notice is provided.
<b>Response:</b>	
<b>1.108</b>	Can your organization implement a separate plan design for specialty drugs that would include generic, preferred brand, and non-preferred brand tiers?
<b>Response:</b>	

1.109	Are your proposed rebate guarantees for your retail/mail program contingent upon the State's purchase of your specialty drug program? Please do not provide actual rebate guarantees in your response..
<b>Response:</b>	
1.110	Does your firm utilize courier services for specialty product delivery? If yes, detail these services and procedures and detail how courier service vehicles maintain temperature control.
<b>Response:</b>	
1.111	Do you limit certain specialty drugs to less than 30 days' supply for a patient's initial prescription? If yes, please indicate which drugs and the days' supply limit.
<b>Response:</b>	
1.112	Please describe your quantity limit rules for specialty drugs and include a list of the quantity limits by drug.
<b>Response:</b>	
1.113	Provide the customer and member service operation hours of your specialty pharmacy program.
<b>Response:</b>	
1.114	Provide a concise description of your member service pharmacist support for specialty drugs, including how many pharmacists provide member support, the hours of their availability and any specialized expertise they hold.
<b>Response:</b>	

1.115	Provide a concise description of the member support services your organization provides to members who utilize oncology specialty drugs.
Response:	
1.116	Provide a brief recommendation of how you would propose to collaborate with the State's medical carriers to optimize patient care and utilization of specialty drugs.
Response:	
1.117	Please indicate any specialty drug categories for which you recommend clients limit coverage to the pharmacy benefit only.
Response:	
1.118	Describe what procedures or management tools your organization has in-place to manage the use of manufacturer coupons for high cost drugs.
Response:	
1.119	Please describe any specialty drug copay assistance programs (e.g. variable copay design, concierge service) available to reduce the State's Plan costs and describe any member impact and Plan requirements to implement.
Response:	
1.120	Provide your organization's definition and qualification criteria of a "specialty drug product."
Response:	
1.121	<p>Provide an AWP-based pricing list of all specialty pharmaceuticals that your company dispenses and distributes to providers and patients. Your pricing should include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:</p> <ul style="list-style-type: none"> <li>a. Product Name</li> <li>b. Therapeutic Group/Therapeutic Category</li> <li>c. Guaranteed Minimum AWP discount for all specialty pharmacy program prescriptions for the exclusive specialty arrangement.</li> <li>d. Bidder shall describe any price inflation guarantee you are putting forth for specialty drugs.</li> </ul>
Response:	

### PHARMACY FEE

**1.122** Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc

**Response:**

**1.123** Detail any data related service fees not included in the base administrative fees.

**Response:**

**1.124** Do your data fees include data warehousing or data mining capabilities? If not, detail any fees associated with this service.

**Response:**

### AWP REIMBURSEMENT

**1.125** Provide detailed information on how often AWP prices are+ updated in your adjudication system.

**Response:**

**1.126** Bidder should provide proposed drug type designation or classification (e.g. brand, generic) source (i.e. First DataBank, Medi-Span, Redbook, Other). If other, please specify

**Response:**

**1.127** Please give the name of the qualifying rebate guarantee class (if applicable).

**Response:**

### CLINICAL MANAGEMENT PROPOSAL

**1.128** How will the State be kept informed of changes to clinical management rules?

**Response:**

1.129	<p>Provide a sample client management report that details clinical rule activity and savings</p> <ol style="list-style-type: none"> <li>Provide a sample of your client clinical management performance report</li> <li>Describe your PA, step therapy and quantity level limit program capabilities</li> <li>Please attach a list of drug categories for which such programs can be applied</li> <li>Briefly describe your drug utilization review (DUR) process and indicate which point-of-sale edits can be overwritten and which are "hard" rejects. Include a list of your point-of-sale edits</li> <li>Provide your detailed utilization management program list, including specific drugs names in each program</li> <li>Provide a sample DUR report you produce and make available to clients</li> </ol>
<b>Response:</b>	
1.130	What was your overall average DUR savings as a percentage of plan cost in 2017?
<b>Response:</b>	
1.131	Briefly summarize the DUR edits that detect fraud and/or abuse.
<b>Response:</b>	
1.132	Describe the "look-back" period utilized for the refill-too-soon edit and indicate whether it includes only the previous claim or cumulative historical claims.
<b>Response:</b>	
1.133	<p>In addition to point-of-sale edits, describe any other tools or programs that are available to detect, prevent, and resolve fraud and/or abuse?</p> <p>Indicate whether such programs are optional and whether they entail a separate fee.</p> <p>Also provide a complete description and samples of any documents used in a separate section of your bid.</p>
<b>Response:</b>	
1.134	Do you require a DEA or other identifier to be indicated to fill a controlled substance drug? If yes, how is the requirement enforced?
<b>Response:</b>	

1.135	Does your prior authorization rule for drugs used to treat Hepatitis-C (Harvoni or Viekira Pack) take into account severity of illness? If yes, please provide a copy of the complete criteria.
Response:	
1.136	Do you include compliance and adherence therapy as a part of your standard package?
Response:	
1.137	Do you report on outcomes for specialty drug management programs (ROI, Clinical Results, etc.)?
Response:	
1.138	Describe your policies for lost medication, vacation supplies, and overseas supplies for prescription early refills.
Response:	
1.139	Provide a detailed description of how your organization determines which drugs are preferred versus non-preferred.
Response:	
1.140	Do you monitor individual physician prescribing patterns? If yes, what action is taken with physicians who have a high degree of non-compliance to improve their compliance?
Response:	
1.141	Briefly describe methods you currently have in place to influence prescribing behavior, if any. Can the State opt-in/out of these programs?
Response:	

1.142	Provide a copy of any physician score card or other reporting that is provided to clients.
<b>Response:</b>	
1.143	Does your organization currently have a managed injectable program? If yes, please briefly describe this program.
<b>Response:</b>	
<b>DIRECT PRIMARY CARE</b>	
1.144	Describe your experience working with Direct Primary Care (DPC) models, as described in Legislative Bill 1119. Include in your response how long you have worked with DPC models and the DPC organizations with whom you have relationships.
<b>Response:</b>	
1.145	Describe the contractual relationship that would exist between you and a DPC Contractor if applicable.
<b>Response:</b>	
1.146	Describe your process to provide administration and management of this Contractor and the services they provide to the State.
<b>Response:</b>	
1.147	How would you integrate a DPC model into your current offerings to provide a seamless experience for the State's membership?
<b>Response:</b>	
1.148	Describe how you will work with the Contractor to administer the DPC model.
<b>Response:</b>	

1.149	What are your processes to exchange data with the DPC Contractor?
Response:	
1.150	How will you integrate data from the DPC Contractor to gain a holistic picture of each member's health profile?
Response:	
1.151	Describe how you administer the wrap plan for the DPC model.
Response:	
1.152	Describe the mechanisms in place to work with the DPC Contractor to ensure the member is referred to their wrap plan for benefits, if treatment outside the DPC model is needed.
Response:	
<b>TRANSPARENCY TOOLS</b>	
1.153	<p>Briefly describe your capabilities regarding member access to:</p> <ul style="list-style-type: none"> <li>a. Physician and hospital quality and/or outcomes data</li> <li>b. Physician and hospital ranking or premium designation</li> <li>c. Physician and hospital pricing data by procedure by provider</li> </ul>
Response:	
1.154	Describe your capabilities toward educating members on price transparency and quality, include any decision matrices to help guide members in making their decision.
Response:	

1.155	Are you able to message members on more cost effective treatment options? For example, if a member has a non-emergent emergency room visit that does not result in a hospital admission, will you message them to suggest alternatives?
Response:	
1.156	Is member messaging available electronically, telephonically, and/or through the mail? What types of messages do you send members?
Response:	
1.157	What steps have you taken toward improving Health Information Technology (HIT)? Describe your progress, state of development, and future commitment in terms of education, communication, awareness, and integration with utilization management
Response:	
<p align="center"><b>IMPLEMENTATION AND COMMUNICATIONS</b></p>	
1.158	<p>Bidder shall provide an implementation plan detailing the implementation timeline with a July 1, 2020 effective date. At a minimum, the Implementation Project Plan must provide specific details on the following:</p> <ul style="list-style-type: none"> <li>a. Identification and timing of significant responsibilities and tasks</li> <li>b. Names, titles, and implementation experience of key implementation staff and time dedicated to the State during implementation</li> <li>c. Identification and timing of the State's responsibilities</li> <li>d. Transition requirements with the incumbent Contractors</li> <li>e. Staff assigned to attend and present (if required) at Open Enrollment</li> <li>f. Data and timing requirements from current Contractors to ensure transition of care and prior-authorization data is appropriately transferred</li> </ul>
Response:	

1.159	Bidder should provide detailed information on how it will communicate to the members. Bidder should provide sample communication materials such as certificate of coverage booklets, up-to-date provider network directories, request letters for clinical programs and sample EOBs.
Response:	
1.160	Bidder shall provide detailed information on how long it will take to print and distribute benefits literature and indicate how long it will take to print and mail identification (ID) cards after receipt of correct eligibility data. During the year, ID cards must be distributed by the Contractor within 10 business days of being notified of the new or changed enrollment by the State.
Response:	
1.161	Bidder shall provide detailed information on its procedures and time frame to prepare for annual Open Enrollment. The State will offer an annual Open Enrollment period during which time covered members may switch their plan of coverage. The Contractor shall provide staff to assist State Human Resource Personnel and Administrative Services – State Employee Benefits with annual Open Enrollment meetings in various locations throughout the State. The Contractor shall have certificate books ready for distribution prior to the State's annual Open Enrollment; State will provide plan designs electronically to Contractor 30 days prior to annual Open Enrollment. Describe your company's timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual workarounds, dates for last pre-OE updates, OE file updates, etc.).
Response:	
1.162	Are you willing to provide a one-time implementation allowance to fund, as approved by the State, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? What dollar amount are you willing to provide?
Response:	
1.163	Describe your involvement and how you will assist members in learning about their benefit options.
Response:	

## WELLNESS PROGRAMS

**1.164** Confirm the availability of and describe how your organization ensures employees have:

- a. Lifestyle coaching.
- b. 24-hour nurse line.
- c. Other Wellness services, including medication adherence education.

**Response:**

**1.165** Describe the process for population risk analysis, population stratification, including predictive modeling with respect to Member outreach.

**Response:**

**1.166** Discuss your predictive modeling capabilities and the ability to benchmark the wellness program and it's financial impact.

**Response:**

**1.167** Describe the process by which you share recommendations for improvement based on risk factors.

**Response:**

**1.168** Describe monitoring activities to identify gaps in care and opportunities for improvement.

**Response:**

**1.169** Discuss affirmative steps that you have employed to promote compliance among members/employees.

**Response:**

**1.170** Provide the following outcomes results, for each of the last two (2) years, for each Wellness service:

- a. Overall and program specific engagement rates (defined as the percentage of Members who are contacted, consent to participate in the program, complete an assessment and schedule a follow-up) and realized ROI for each program offered including:
  - i. 24 hour nurse line
  - ii. Lifestyle coaching
  - iii. Other Wellness services
- b. Member participation and ROI for incentive programs.
- c. Provider satisfaction survey results.

	<ul style="list-style-type: none"> <li>d. Member satisfaction survey results.</li> <li>e. Clinical measures for each Wellness services provided.</li> <li>f. Gaps in care closures.</li> <li>g. Changes in Member-reported physical and mental health status through a tool.</li> </ul>
<b>Response:</b>	
1.171	Discuss affirmative steps that you have employed to promote compliance among members.
<b>Response:</b>	
1.172	Confirm and describe your ability to provide dedicated or designated health coaches, lifestyle coaches, exercise physiologists, nutritionists, behavioral health specialists, maternity specialists or other clinical staff to carry out Wellness activities such as health risk assessment, telephonic coaching interventions including lifestyle coaching, a 24-hour nurse line and education about treatment options and health education to empower Members to manage their health.
<b>Response:</b>	
1.173	Describe outreach strategies including those for reaching Members with incomplete contact information. If outreach strategies vary by risk level or program, describe each of the different strategies and when each is used.
<b>Response:</b>	
1.174	What is your health risk assessment completion rate?
<b>Response:</b>	
1.175	Who administers data collection and evaluation?
<b>Response:</b>	

1.176	<p>Confirm availability and describe each of the following programs and/or services:</p> <ul style="list-style-type: none"> <li>a. Health Risk Assessment (both web-based and telephonic) with Individual action steps</li> <li>b. Online biometric tracking tools</li> <li>c. Blood pressure, blood sugar, BMI/weight and other online trackers</li> <li>d. Self-management education and goal-setting</li> <li>e. Nutrition</li> <li>f. Physical activity and related online trackers</li> <li>g. Prenatal care</li> <li>h. Tobacco cessation</li> <li>i. Stress management</li> <li>j. Weight management</li> <li>k. Injury prevention</li> <li>l. Preventive service reminders, sent by mail, phone or electronically</li> <li>m. Gaps in care reminders, sent by mail, phone or electronically</li> <li>n. Type of smart innovative health programming, i.e., smart phone tracking, Fit Bit, etc.</li> </ul>
<p><b>Response:</b></p>	
1.177	<p>How do you define wellness-coaching success?</p>
<p><b>Response:</b></p>	
1.178	<p>How does your concept of success relate to improvement in employee population health risks?</p>
<p><b>Response:</b></p>	
1.179	<p>How risk stratification conducted?</p>
<p><b>Response:</b></p>	
1.180	<p>Provide the ROI calculation methodology for the overall Wellness program.</p>
<p><b>Response:</b></p>	

1.181	How do you define and measure wellness outcomes related to your programming structure?
Response:	
1.182	Describe your program that manages gaps in clinical care, beginning with the identification process and concluding with outcome
Response:	
1.183	<p>Confirm and describe the following tools and services available to Members via the Member portal:</p> <ul style="list-style-type: none"> <li>a. Health Risk Assessment.</li> <li>b. Wellness tools and trackers.</li> <li>c. Health promotion and health education tools.</li> <li>d. Any other web tools to support Wellness activities.</li> <li>e. Health services related to member cost</li> </ul>
Response:	
1.184	Provide a description, capabilities, benefits and execution process of all Wellness Programs that could be made available to the State
Response:	
<b>CURRENT AND FUTURE INNOVATIVE INITIATIVES</b>	
1.185	<p>Describe any such initiatives currently offered to self-funded groups such as the State. Describe how these initiatives can be implemented in the State's health plans and the incremental costs of the ASO fees. If any of these innovative initiatives are in development or in the planning stages for the future, provide any information available to allow the State to understand your concepts for developing each initiative. Include information on the expected implementation of such initiatives in Nebraska, when they are available to the State plans and the expected impact on program costs. Such initiatives may include, but are not limited, to the following:</p> <ul style="list-style-type: none"> <li>a. High Performance Networks or narrow networks</li> <li>b. Patient-Centered Medical Home models</li> <li>c. Accountable Care Organizations</li> <li>d. Telemedicine/Virtual Visits</li> <li>e. Other value-added services</li> </ul>
Response:	

## CORPORATE OVERVIEW

1.186

### BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business, whether the name and form of organization has changed since first organized, and Federal Employer Identification Number and/or Social Security Number. Dunn & Bradstreet, Inc. number (if known). Provide the total national membership (number of contracts) that receives medical administration services from your organization and indicate how many of these are in Nebraska

Response:

1.187

### FINANCIAL STATEMENTS AND INFORMATION

The bidder should provide financial statements applicable to the firm. Bidder should provide a copy of the bidder's most recent annual report. If publicly held, the bidder should provide a copy of the corporation's most recent 2 years of audited financial reports and statements, and the name, address and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

Bidder should indicate the most recent Financial Rating, Financial Rating Modifiers and the Financial Rating Effective Date you have received by the following organizations. Indicate all changes that have occurred in the last 12 months for each of these ratings.

- a. A.M.Best
- b. Standard and Poors
- c. Moody's
- d. Fitch

Response:

1.188	<p><b>CHANGE OF OWNERSHIP</b></p> <p>If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor will require notification to the State.</p> <p>Please describe any parent/subsidiary relationship</p>
Response:	
1.189	<p><b>OFFICE LOCATION</b></p> <p>The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified</p>
Response:	
1.190	<p><b>RELATIONSHIPS WITH THE STATE</b></p> <p>The bidder describe any dealings with the State over the previous twelve (12) months. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.</p>
Response:	
1.191	<p><b>BIDDER'S EMPLOYEE RELATIONS TO STATE</b></p> <p>If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.</p> <p>If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.</p>
Response:	

<p><b>1.192</b></p>	<p><b>CONTRACT PERFORMANCE</b></p> <p>If the bidder or any proposed subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.</p> <p>It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.</p> <p>If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.</p>
<p><b>Response:</b></p>	
<p><b>1.193</b></p>	<p><b>SUMMARY OF BIDDER'S CORPORATE EXPERIENCE</b></p> <p>The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.</p> <p>The bidder must address the following:</p> <ol style="list-style-type: none"> <li>1. Bidder must provide three narrative descriptions to highlight the similarities between their experience and this Request for Proposal. These descriptions must include: <ol style="list-style-type: none"> <li>a. The time period of the projects;</li> <li>b. The scheduled and actual completion dates;</li> <li>c. The Contractor's responsibilities;</li> <li>d. The number of contracts and the number of covered members for each project;</li> <li>e. for reference purposes, three customer names (including the names of a contact person, current telephone numbers, facsimile numbers and e-mail addresses); and</li> <li>f. Each project description shall identify whether the work was performed as the prime Contractor or as a subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion dates and budget, as well as the actual (or currently planned) completion dates and actual (or currently planned) budget.</li> </ol> </li> </ol>

2. Contractor and subcontractor(s) experience must be listed separately. Narrative descriptions submitted for subcontractors must be specifically identified as subcontractor projects.
3. If the work was performed as a subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.
  - a. Is this an exclusive relationship?
  - b. Effective date of Subcontract?
4. Please indicate how many years your organization has been in the business of providing and administering the coverage(s) for which you are submitting an RFP. Briefly describe your ability to administer such plans including:
  - a. Health Savings Accounts
5. For your entire book of business, provide the total year-end national group membership (number of contracts) that receives medical administration services from your organization and indicate how many of these are in Nebraska. Please also provide statistics for your Public Sector clients

	National Group Membership (Number of Contracts)	Nebraska Group Membership Number of Contracts)	Number of Public Sector Groups	Number of Public Sector Groups with 15,000+ lives
2016				
2017				
2018				

6. What percentage of your 2017 total group membership renewed for the 2018 plan year?

**Response:**

1.194	<p><b>SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH</b></p> <p>The bidder must present a detailed description of its proposed approach to the management of the project.</p> <p>The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified. The team shall include, but not be limited, to the following roles:</p> <ul style="list-style-type: none"> <li>a. Implementation Manager</li> <li>b. Account Executive</li> <li>c. Clinical Pharmacist</li> <li>d. Operations Director</li> <li>e. Network Manager</li> <li>f. Member Services Manager</li> </ul> <p>*Designated alternate Account Manager would be expected to be familiar with all aspects of the State's business as it relates to the State's Health Plan. The Designated alternate Account Manager is not subject to the location requirements, but must be available via a conference call.</p> <p>The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.</p> <p>Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.</p>
Response:	
1.195	<p><b>SUBCONTRACTORS</b></p> <p>If the bidder intends to subcontract any part of its performance hereunder, the bidder must provide:</p> <ul style="list-style-type: none"> <li>a. name, address and telephone number of the subcontractor(s);</li> <li>b. specific tasks for each subcontractor(s);</li> <li>c. percentage of performance hours intended for each subcontract; and</li> <li>d. total percentage of subcontractor(s) performance hours.</li> <li>e. advise if exclusive relationship for each subcontractor; and</li> <li>f. Indicate effective date and expiration date of each Subcontract agreement.</li> </ul>
Response:	